STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING _____ B. WING _____	10/03/2017

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DELMAR NURSING & REHABILITATION CENTER	101 E. DELAWARE AVENUE DELMAR, DE 19940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 25, 2017 through October 3, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was eighty five (85). The stage 2 survey sample was thirty four (34). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; SW - Social Worker LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; Agitation - feeling restless, not calm; Anxiety - feeling worried, nervous or restless; Ativan - drug to treat anxiety; Blood pressure - the measure of the force of blood against the walls of a blood vessel; Cognition - mental processes or thinking; Delusion -false belief that is thought to be true; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes; eMAR - Electronic Medication Administration Record (in the computer); eTAR - Electronic Treatment Administration Record (in the computer); EMR - Electronic Medical Record;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/24/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Heart failure (congestive heart failure - CHF) - heart cannot pump enough blood to meet the body's needs and fluid builds up in the body; Hospice - service that provides care to residents who are terminally ill; HR - Human Resources; Hydromorophone (Dilaudid) - pain medication; Ibuprofen-Advil-anti-inflammatory medication used to treat pain and/or fever; i.e. - that is; Incontinence - loss of control of bladder and/or bowel function; MDS (Minimum Data Set) - standardized assessment used in nursing homes; mL (milliliter) -unit of liquid volume, 5 ml equals 1 teaspoon; Naproxen - pain medication; PAINAD (Pain Assessment in Advanced Dementia) Pain Rating Scale - Determine pain rating on 0 - 10 scale in those with advanced dementia by looking at behaviors; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Pressure Ulcers (PUs) - sore area of skin that develops when blood supply to it is cut off due to pressure; Pre - before; Post - after; PRN - as needed; Prompted void - technique of bladder training in which the patient is instructed to urinate according to a predetermined schedule; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; Slough - yellow, tan, gray, green or brown dead tissue; Stage II (2) PU - blister or shallow open sore with red/pink color;	F 000		

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F 000	Continued From page 2 Stage III (3) PU - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin; Systolic Blood Pressure - top number of the blood pressure reflecting pressure in vessels when the heart is beating; Tylenol-medication for pain, TB-tuberculosis, lung infection; Wong Baker FACES Pain Rating Scale - instructions for this pain scale included to explain that each face is for a person who has no pain, some pain or a lot of pain. Face 0 does not hurt at all, face 2 hurts just a little more, face 4 hurts a little bit more, face 6 hurts even more, face 8 hurts a whole lot and face 10 hurts as much as you can imagine. Although you don't have to be crying to have this worst pain. Ask the person to choose the face that best depicts the pain they're experiencing; x 2 - two times.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225		11/27/17

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F 225	Continued From page 3 or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

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F 225	Continued From page 4 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to immediately report and thoroughly investigate an allegation of abuse for one (R23) out of 34 sampled residents. Findings include: 1. The following was reviewed in clinical records and also in facility documents as indicated below : 7/27/17- A complaint form completed by E6 (RN) documented that R23 "states that R33 [another resident] touched her breast." 7/27/17 - A verbal statement from R23, attached to the 7/27/17 complaint form, documented by E6 "Resident [R23] states that about 3 months ago R33 touched her breast. R23 states he (R33) was going past her in the hallway at the nurses station and his hand touched her breast while he was going by. R23 stated she did not feel abused by the occurrence, he is just a dirty old man." 7/28/17 - A statement form, attached to the 7/27/17 complaint form, written by E6 documented "this nurse along with social worker [E7] spoke with R33 regarding touching R23's breast...Resident [R33]made aware that any touching of other residents or staff members is unacceptable. Resident [R33] made aware that	F 225	Delmar Nursing and Rehabilitation Center's plan of correction for the deficiencies noted during our annual survey ending October 3, 2017 is not an admission to the deficiencies, but our desire to show compliance with all Federal and State regulations. F225 Corrective Measures for resident affected: R23 is alert and oriented, and upon investigation, denied that the inappropriate touch was sexual abuse. The facility obtained statements, updated care plans and provided education to the other resident involved. R23 stated that this was not sexual abuse. The facility has completed a report to Division of Long Term Care, Residents Protection. (Exhibit one) Identification of Others with the Potential to be Affected: LNHA or designee will complete a review of grievances completed over the last 90 days to ensure that the facility accurately identified potential abuse cases and	

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F 225	Continued From page 5 behavior is inappropriate and can be considered sexual abuse." During an interview on 9/29/17 at 11:48 AM with E6 it was confirmed that E6 did not report R23's incident because it was not recognized as an allegation of abuse. E6 stated "I couldn't get a clear picture from R23 of when it happened and if it had been reported to staff. If I felt like it was sexual abuse I would have reported it to the state." E6 stated she "investigated it through the complaint form with the statements I had received." E6 confirmed no protection was offered to R23 because "I did not feel like it was appropriate because when I spoke to R23, she did not feel like it was abuse and I spoke to the other resident regarding that it was inappropriate behavior". E6 confirmed that she was aware that R33 had a care plan for behaviors of inappropriate touching. During an interview on 9/29/17 at 1:00 PM with E2 (DON) it was reported that after speaking with R23 to ensure "she was fine with the facility doing education with R33" that was the resolution of the incident. When asked was the allegation of abuse investigated E2 stated "the abuse investigation was the question did R23 feel abused, once she stated no we did not identify it as abuse." E2 denied clarification on what R23 meant by the statement "dirty old man." E2 confirmed this allegation was not reported to the state agency. During an interview on 9/29/17 at 1:13 PM with E7 (SW) it was confirmed that R23's report of being touched on the breast by another resident, was not recognized as an allegation of abuse. E7 then reported that she did talk and educate the other resident about the importance of not	F 225	reported to the appropriate agencies. (Exhibit 2) Measures to Prevent Recurrence: LNHA provided one on one education to facility DON regarding reporting potential abuse cases to the Division of Long Term Care Residents Protection. Although the investigation was completed and the allegation was unsubstantiated based on the alert and oriented response of R23, the expectation going forward is that the facility would report the potential for abuse, even if it was unfounded. (Exhibit 3) Facility Staff Educator or designee will complete abuse education with facility staff to include definitions of abuse and the facility abuse policy. (Exhibit 4) The facility will review grievance during normal business days during the facility IDT meeting daily to ensure that all potential abuse concerns have been appropriately investigated and reported to the DLTCRP. During the weekend shifts, the facility Supervisor or designee will review all grievances for the same and review with facility LNHA/DON for reporting guidance. Monitoring of Corrective Measures: Facility LNHA or designee will complete audits of facility grievance forms to ensure that any potential abuse was reported immediately to DLTCRP. The audits will	

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F 225	Continued From page 6 touching others without permission. During an interview on 10/3/17 at 10:06 AM with E2 it was explained the determination of whether an allegation meets criteria for abuse is determined by the residents, E2 stated "the way we handle it here its based on the resident perception." This finding was reviewed with E1 (NHA) and E2 on 10/3/17 at 11:30 AM.	F 225	occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 2)	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 272		11/27/17

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F 272	Continued From page 7 (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R35) out of 34 sampled residents the facility failed to accurately assess R35 on the MDS. Findings include: Review of R35's clinical record revealed: 12/8/16 - Annual MDS assessment for Dental indicates that R35 does not have any dental issues. 9/25/17 at 11:05 AM - Observation of R35 revealed R 35 has missing, broken and carried teeth.	F 272	F272 Corrective Measure for Resident Affected: There was no negative outcome to R35. A MDS revision was completed on September 29, 2017 that accurately reflects R35□s dental status. Identification of Others with the potential to be affected: Facility Nurse Managers or designee have completed an audit to assess current resident□s dental status. Audit results have been compared to the most recent	

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F 272	Continued From page 8 During an interview with E4 (UM, LPN) on 9/28/17 at 10:30 AM about the resident dental status E4 said R35 has not made any complaints about her teeth. He did recall that they had taken her to dentist but that it was some time ago he was not sure of the outcome. 9/29/17 at 1:01 PM - E2 (DON) provided a copy of a dental visit from 10/15/15 and the dentist indicated that there was an abscess to a tooth. Patient does not want a tooth extraction. The diagnosis was R35 needs extraction of a tooth but she refuses treatment. Findings reviewed with E2 at this time about the the absence of a follow up assessment The facility failed to reassess R35's dental status during the annual assessment. These findings were reviewed with E1 (NHA) and E2 on 10/3/17 at 11:30 AM	F 272	annual MDS assessment to ensure accurate coding. (Exhibit 5) Measures to Prevent Recurrence: The MDS Coordinator that completed the 12/08/2016 assessment is no longer an employee at the facility. Current facility MDS coordinator received one on one education related to the importance of accurately coding the resident□s dental status. (Exhibit 6) Facility Nurse Managers will review the resident dental assessment data for annual assessments prior to submission to ensure accuracy of coding. (Exhibit 27) Monitoring of Corrective Measures: Facility DON or designee will complete audits of facility resident annual dental assessments to ensure that an accurate reflection of the resident□s current dental assessment is coded on the MDS. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 5)	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		11/27/17

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F 279	Continued From page 9 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		

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F 279	Continued From page 10 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a care plan with goals to address pain for three (R94, R93, and R83) out of 5 sampled residents reviewed for unnecessary medications. Findings include: Undated facility policy entitled Pain Management and Documentation (copy provided during survey) included that the interdisciplinary team in conjunction with the resident will formulate an interdisciplinary care plan that will address: causes/sources of pain; goals to manage pain; interventions (pharmacologic and non-pharmacologic); and Evaluation of pain management program.	F 279	F279 Corrective Measures for Residents Affected: A person centered pain care plan was developed and implemented on R94 on October 23, 2017. A person centered pain care plan was developed and implemented on R93 on September 29, 2017. A person centered pain care plan was developed and implemented on R83 on September 29, 2017. There was no negative outcome to the residents affected. All had a pain management program in place to address	

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F 279	Continued From page 11 1. Review of R94's clinical record revealed: June - September, 2017 - Review of eMARs showed R94 received 12 doses of PRN medication for pain. Current care plan did not include pain. During an interview with E5 (UM) on 9/28/17 at 9:30 AM E5 confirmed the care plan did not include pain. 2. Review of R93's clinical record revealed: 5/19/17 - Care plan for Comfort/Pain included the goal to participate in ADLs and rehabilitation. The pre-printed option of "Decrease in pain after reducing measures" was not marked. June - September, 2017 - Review of eMARs showed R93 received PRN Tylenol 19 times for pain. Current care plan did not include goal of obtaining relief after reducing measures like PRN Tylenol. During an interview with E5 on 9/28/17 at 9:30 AM E5 confirmed the care plan did not include pain. 3. Review of R83's clinical record revealed: June - September, 2017 - Review of eMARs showed R83 received PRN Tylenol 7 times for pain. Current care plan did not include pain. During an interview with E6 (UM) on 9/28/17 at	F 279	their pain needs. Identification of others with the potential to be affected: Facility Nurse Managers have completed an audit of facility residents to identify residents at risk for pain and to ensure that a person centered care plan is in place to manage the resident□s pain risk. (Exhibit 7) Measures to Prevent Recurrence: Facility licensed nursing staff have received education on the importance of identifying the residents risk for pain and developing a person centered care plan to address the residents pain risk. (Exhibit 4) Facility Nurse Manager□s admission chart audit tool has been updated to reflect the need for implementation of a person centered risk for pain/pain care plan based on the residents individualized pain assessment. This tool is to be completed within 72 hours post admission and returned to the facility DON. (Exhibit 8) Monitoring of Corrective Measures: The facility DON or designee will audit facility residents to ensure that the individuals risk for pain is appropriately identified upon admission and with significant change in condition and that an individualized person centered care plan is in place to manage the residents risk	

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F 279	Continued From page 12 11:35 AM E6 confirmed the missing pain care plan. These findings were reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM.	F 279	for pain based off of the pain assessment. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 7)	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		11/27/17

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F 280	Continued From page 13 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 280		

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F 280	Continued From page 14 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise the care plan for one (R50) out of 34 sampled residents when interventions for urinary incontinence changed. Findings include: Review of R50's clinical record revealed: 10/26/16 - Care plan problem urinary incontinence included the intervention for prompted voiding every 2 hours while awake. 5/8/17 - Significant change MDS assessment documented R50 was admitted to hospice and was not on a toileting plan. During an interview with E5 (UM) on 9/28/17 at 2:15 PM E5 confirmed that once R50 was on hospice prompted voiding was not possible since the resident could not get to bathroom. E5 added that "Near the end she was just changed." These findings were reviewed with E1 (NHA) and	F 280	F280 Corrective Measure for Resident Affected: R50 no longer resides at the facility. There was no negative outcome to R50. Identification of others with the potential to be affected: Facility residents with urinary incontinence have the potential to be affected. Facility Nurse Managers completed an audit of facility residents with urinary incontinence to ensure that the incontinence care plan is an accurate reflection of the resident□s current status and incontinence needs. (Exhibit 9) Measures to Prevent Recurrence: Education was completed with licensed nursing staff on the importance of	

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F 280	Continued From page 15 E2 (DON) on 10/3/17 at 11:30 AM.	F 280	completing an accurate assessment of the facility resident□s elimination status. This education included the need to complete an accurate assessment and initiating/updating the residents individualized care plan to reflect the resident□s current needs after a significant change in condition has been noted. (Exhibit 4) DON completed one on one education with the facility MDS Coordinator related to the need to ensure that the residents individualized person centered care plans have been reviewed and revised as necessary to capture an accurate reflection of the resident□s needs after a significant change in condition. This education also included the need to bring any resident with a significant change to the facility IDT meeting to review. (Exhibit 6) The facility IDT will review resident□s with a significant change in condition to ensure that the resident□s plan of care is individualized and addressed the current problems and needs of the resident. This will occur at the daily IDT clinical meeting. Monitoring of Corrective Measures: Facility DON or designee will complete audits of facility residents with a significant change in condition to ensure that the continence care plan is person centered and individualized to the resident□s current status and needs. The audits will occur on the following schedule: Daily	

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F 280	Continued From page 16	F 280	until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 9)	
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		11/27/17

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F 309	Continued From page 17 the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide care and services according to the physicians' orders for six (R94, R93, R83, R103, R38 and R92) out of 33 sampled residents. For R94, R93, R83, R38 and R92 there was no assessment of pain intensity before and/or after PRN pain medication. For R103, intake was not monitored to determine if the fluid restriction was being followed. Additionally for R93 the facility failed to consistently monitor blood pressures. Findings include: 2002 - Pain management standards from the American Geriatrics Society included: Appropriate assessment and management of pain; Assessment in a way that facilitates regular reassessment and follow-up; Same quantitative pain assessment scales should be used for initial and follow up assessment; Set standards for monitoring and intervention; and Collect data to monitor the effectiveness and appropriateness of pain management. Undated facility policy entitled Pain Management and Documentation (copy provided during survey) included the following procedure: - Resident's pain will be rated using one of the	F 309	F309 Corrective Measures for Residents Affected: R103 no longer resides at the facility. There was no negative outcome to R103. R94□s Physician orders for PRN pain medication in the electronic medical record has been updated to make the pre and post pain assessment as well as location a mandatory task to sign off the medication. There was no negative outcome to R94. R93□s Physician orders for PRN pain medication in the electronic medical record has been updated to make the pre and post pain assessment as well as location a mandatory task to sign off the medication. R93□s blood pressure medication orders have been updated in the electronic medical record to make the documentation of the resident□s blood pressure a mandatory task to sign off the order. Medication error forms were completed for June 1, July 10 and	

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F 309	Continued From page 18 scales (Wong Baker Faces, Numerical, PAINAD). - The PRN Pain Flowsheet will be initiated by the licensed nurse when a PRN pain medication is ordered for: Location; Initial pain evaluation; Evaluate the effectiveness of interventions; and Monitor effectiveness of pharmacologic or alterative interventions. - Nurses are to document any time a PRN pain medication is administered along with effectiveness. Facility policy entitled Medication Administration (last revised 11/15/16) included that: - Vital signs and/or parameters must be checked/verified for each resident prior to administering medications. - The individual administering the medication will record in the medical record: any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed. 1. Review of R103's clinical record revealed: 6/17/17 - Admission after dinner from hospital with multiple diagnoses including heart failure. 6/17/17 - Physicians' orders included regular diet with 1500 mL fluid restriction. 6/19/17 - Care plan problem for Respiratory and Cardiac [heart] Function related to heart failure and chronic lung disease [difficulty breathing] included the goal to be free of respiratory and cardiac distress. Interventions included to encourage adequate nutritional and fluid intake per nutritional care plan. 6/22/17 - Care plan for Potential for alteration in	F 309	September 7, 2017. There was no negative outcome to R93. R83□s Physician orders for PRN pain medication in the electronic medical record has been updated to make the pre and post pain assessment as well as location a mandatory task to sign off the medication. There was no negative outcome to R83. R92□s Physician orders for PRN pain medication in the electronic medical record has been updated to make the pre and post pain assessment as well as location a mandatory task to sign off the medication. There was no negative outcome to R92. R38□s Physician orders for PRN pain medication in the electronic medical record has been updated to make the pre and post pain assessment as well as location a mandatory task to sign off the medication. There was no negative outcome to R38. Identification of others with the potential to be affected: Facility residents with a PRN Pain medication have the potential to be affected. Facility Nurse Managers completed an audit of facility residents to ensure that the pre and post pain assessment as well as location is a mandatory task in the electronic medical record. (Exhibit 10)	

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F 309	Continued From page 19 nutrition status related to fluid restriction 1500 mL daily. Interventions included to provide diet, honor food preferences, follow via meal rounds. 6/23/17 - Physicians' orders specified the breakdown of the fluid restriction by meal and amount available for medication administration and between meals (240 mL breakfast, 360 mL lunch, 360 mL dinner, 540 mL nursing). June 2017 - Review of CNA documentation for fluid intake at meals found; - Missing meal intake (June 18: all three meals; June 19: breakfast; June 24: breakfast; and June 26: lunch). - Fluid intake when all meals recorded ranged from 720 mL - 1,140 mL. During an interview with E4 (UM) on 9/29/17 at 1:00 PM E4 acknowledged the amount of fluid intake was included in the computer only for the CNAs since "it was put under dietary." E4 added that nurses "usually give 120 cc's (same as mL) with med pass." Review of the eMAR found the following medication administration times were 6 AM, 8 AM, 2 PM, 8 PM, 9 PM, 10 PM. The UM added that R103 had been in and out of the hospital prior to admission to the facility. It was "difficult to manage fluid balance." There was no evidence in the record that total fluid intake was monitored to determine if the resident was drinking too much or too little. 2. Review of R94's clinical record revealed: 3/2/17 - Readmission to the facility after a failed attempt to live at home. Admission physicians' orders included two PRN medications for pain	F 309	Facility residents receiving blood pressure medications with parameters have the potential to be affected. Facility Nurse Managers completed an audit of facility residents receiving blood pressure medications with parameters to ensure that the blood pressure documentation is a mandatory task in the electronic medical record. (Exhibit 11) Measures to Prevent Recurrence: Facility Licensed nurses received education on how to complete the physician orders to make the documentation of the pre and post assessment as well as location as a mandatory tasks. The nurses were given a competency to show proficiency in this task. The education also included the need to review the blood pressures prior to administration of the blood pressures to ensure that they are in compliance with physician order. (Exhibit 4, Exhibit 12) Physician Orders will now have the pre and post documentation of the resident pain assessment as well as location as a mandatory task in the electronic medical record. Documentation of the blood pressure for blood pressure medications requiring parameters will now be a mandatory task in the electric medical record. Monitoring of Corrective Measures: Facility DON or designee will complete audits of pre and post pain assessments for PRN pain medication to ensure that	

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F 309	Continued From page 20 (ibuprofen and Tylenol). 5/8/17 - Care plan problem for Comfort/Pain included the intervention to identify, monitor and document presence of pain or discomfort; Monitor for effectiveness of pain medication/pain modalities. June - September 2017 - Review of eMAR, pain assessment and nursing notes revealed R94 received 5 doses of ibuprofen and 7 doses of Tylenol for pain. All administrations were lacking assessment of pain using the pain scale before and after the PRN medication: a. Ibuprofen - missing pre assessment of pain rating: July 16 and 21. - missing pre and post assessment of pain rating and location: June 3, July 30 and August 26. b. Tylenol - missing pre assessment of pain rating: August 8 and 23. - missing post assessment of pain rating: July 12. - missing pre and/or post assessment of pain rating and location: July 7 and 16, August 22 and 28. During an interview with E5 (UM) on 9/28/17 at 8:49 AM E5 confirmed the missing assessments surrounding R94's PRN pain medication. 3. Review of R93's clinical record revealed: a. Pain Assessment 12/1/16 - Admitted to facility with admission physicians' orders including Tylenol PRN for pain.	F 309	the assessments including location were completed pre and post administration. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 13) Facility DON or designee will complete audits of facility residents receiving blood pressure medications that require blood pressure monitoring to ensure that the blood pressure was taken and the medication was administered based on the parameters if applicable. . The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 14)	

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F 309	Continued From page 21 5/19/17 - Care plan problem for Comfort/Pain (use non verbal scale) included interventions to medicate per orders, monitor effectiveness, monitor for adverse effects. June - September, 2017 - Review of eMAR, pain assessment and nursing notes found that 18 of the 19 PRN medication administrations for pain the resident received lacked assessment: - missing pre and post assessment of pain rating: August 1, 9 (two doses), 13, 30 and 31; September 9, 17, 18, 19 and 24. - missing pre and/or post assessment of pain rating and location: June 6, 22 and 25; July 28; September 4, 6, 20. During an interview with E5 (UM) on 9/28/17 at 9:30 AM E5 reviewed the EMR with the surveyor and confirmed the missing assessments. b. Blood Pressure Assessment 12/1/16 - Physicians' orders included a medication for blood pressure (BP) to be given twice a day and to hold the dose if the systolic BP was below 100. June - September, 2017 - Review of eMAR, blood pressure monitoring and nursing notes discovered: - 3 out of 21 instances when the evening blood pressure was lower than the parameter but the medication was administered (June 1, July 10 and September 7) - 10 times the medication was administered and no blood pressure was assessed (morning - June 13; evening - June 8, 9, 19, 21, 22, 26, 29, 30 and Aug 4).	F 309		

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F 309	Continued From page 22 During an interview with E5 (UM) on 9/28/17 at 9:38 AM E5 confirmed the three instances the medication should have been held and the many missing blood pressure assessments after double checking the EMR for each entry. Cross Refer F279, Example 3. 4. Review of R83's clinical record revealed: 4/30/16 - Physicians' orders included Tylenol to be given PRN for pain. June - September, 2017 - Review of eMAR, pain assessment and nursing notes showed the resident received 7 doses of PRN medication for pain and all 7 were lacking assessments: - missing pre and post assessment of pain rating: June 15 - missing pre and/or post assessment of pain rating and location: June 26; July 30; August 13; September 16, 19 and 24. During an interview with E6 (UM) on 9/28/17 at 11:35 AM E6 reviewed the EMR and confirmed that pain rating scores assessed were not within a reasonable time frame. E6 added that s/he attached prompts in the computer for the nurse to enter pain severity rating before and after PRN pain medication. 5. Review of R92's record review revealed: Physician Orders for 2 pain medications: Tylenol PRN for pain (12/1/16) and Naproxen PRN for pain. (3/9/17) 4/18/17 - Care plan problem for comfort/pain included: will maintain a pain level below acceptable pain of 2/10 on the pain scale, interventions to identify, monitor and document	F 309		

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F 309	Continued From page 23 presence of pain or discomfort; Monitor for effectiveness of pain medication/pain modalities. August - September 2017 - Review of eMAR R92 received pain medication on 9 out of 9 occasions without a pre or post assessment or location of pain identified. August -missing pre / post and location of pain: 8/3, 8/24, 8/28 September -missing pre / post and location of pain: 8/7, 8/11 x 2, 8/13, 8/14 During an interview on 9/29/17 at 3:08 PM with E2 (DON) it was confirmed that no additional documentation was available for pain assessments for R92. There was no evidence in the record that suggest required monitoring of the administration of pain medication. 6. Review of R38's record review revealed: 5/7/17 - R38 Care plan problem for comfort/pain included: will experience a decrease in pain daily after pain reducing measures are implemented through the next review, interventions identify, monitor, and document pain or discomfort; Monitor for effectiveness of pain medication/pain modalities. 8/3/17 Physicians Orders for hydromorophone (Dilaudid) PRN for pain. Protocol: monitor pain and follow up in 60 minutes.	F 309		

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F 309	Continued From page 24 August - September, 2017 - Review of eMAR, pain assessment and nursing notes found that 41 of the 66 PRN medication administrations for pain the resident received were lacking assessment of pain location or use of the pain scale before and after the PRN medication: August -missing post assessment of pain rating: 8/7 x 2, 8/9 x 2, 8/16, 8/17, 8/18, 8/19, 8/23 x 2, 8/25 x 2, 8/28 x 2, 8/30 x 2 August -missing pre assessment of pain and location of pain: 8/12 September -missing post assessment of pain rating: 9/1, 9/6, 9/7 x 2, 9/7, 9/8, 9/10, 9/11, 9/12, 9/13, 9/16, 9/19, 9/20 x 2, 9/25, 9/27, 9/28, 9/29 -missing pre and post pain assessment: 9/2 -missing pre: 9/3 -missing pre / post and location of pain: 9/4 x 2, 9/5, 9/8, 9/11 -missing post pain assessment and location: 9/6 During an interview on 9/29/2017 at 3:08 PM it was confirmed with E2 (DON) that there was no additional documentation available for pain assessments on R38. These findings were reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM.	F 309		
F 314	483.25(b)(1) TREATMENT/SVCS TO	F 314		11/27/17

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F 314 SS=D	Continued From page 25 PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R82) out of 34 sampled residents the facility failed to ensure weekly PU wound assessments were conducted weekly to promote healing. Findings include: The following was reviewed in R82's clinical record: 6/25/17 - Significant change MDS documented the presence of a stage 3 PU. 8/14/17 - Wound Evaluation Form documented a stage 3 PU to right buttock with a visual appearance of a stage 2 current status improved. 8/25/17 - Wound Evaluation Form documented as above and noted to have no change from last	F 314	F314 Corrective Measures for Resident Affected: R82 is followed weekly by the wound consultant. There was no negative outcome to R82. Identification of others with the potential to be affected: Facility residents with pressure ulcers have the potential to be affected. Facility Nurse Managers completed an audit to identify facility residents with pressure ulcers to ensure that weekly wound evaluations are occurring. (Exhibit 15)	

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F 314	Continued From page 26 assessment. There was an 11 day gap between these assessments. 9/8/17 - Wound evaluation Form (14 days after the last assessment) documented the presence of slough to the wound. 9/28/17 10:17 AM - Interview with E2 (DON) and E4 (UM) confirmed that there were no weekly wound assessments available in the clinical record for August 2017. E4 stated they would contact the contract wound nurse to see if s/he could send them over. Later in the day wound measurement sheets were provided for 8/7, 8/14 and 8/25/17. 10/03/17 10:58 AM - Interview with E2 confirmed no further weekly wound assessments could be found. Theses findings were reviewed with E1 (NHA) and E2 on 10/3/17 at 11:00 AM.	F 314	Measures to Prevent Recurrence: DON completed one on one education with facility nurse managers on the importance of ensuring that weekly wound assessments are completed. Education included manager completion of the assessment if the NP wound consultant is not available. (Exhibit 16) Facility pressure ulcers will be reviewed weekly in the clinical IDT meeting to ensure the wound assessments have been completed weekly. Monitoring of Corrective Measures: DON or designee will complete audits to ensure weekly wound evaluations occur on residents with pressure ulcers. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 15)	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		11/27/17

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F 329	Continued From page 27 drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure three (R94, R93 and R83) out of 5 sampled residents	F 329	F329 Corrective Measures for Resident	

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F 329	Continued From page 28 for medication review were free from unnecessary PRN medications, including those to treat anxiety. Findings include: Facility policy entitled Psychotropic Medications / Behavior Monitoring (initiated 9/15/17) included that the behavior monitoring form will include the behavior(s) to be monitored; possible interventions for the behavior care plan; interdisciplinary team will review the tracker and discuss interventions' effectiveness and will make changes to the behavior care plan as needed. 1. Review of R94's clinical record revealed: Physicians' orders for PRN medications included: - 3/3/17: Allergy medication daily PRN. - 3/6/17: Anxiety medication twice a day PRN. - 5/12/17: Cough medication four times a day PRN. 5/8/17 - Care plan problem for Behavior Symptoms documented R94 has the following behaviors: delusions (talking to people not there, looking for mother, waiting for bus); verbal behavioral symptoms directed towards others (yelling and cursing); wandering (pacing), restlessness (standing unassisted). June - September 2017 - Review of eMARs, nursing notes and behavior monitoring sheets completed by nursing included the behaviors of anxiety from delusions, pacing and agitation. Many doses of PRN medications lacked resident assessment before and/or after administration: a. Allergy: 2 out of 2 PRN doses lacking assessment of resident symptoms before and after medication, July 10 and August 28	F 329	Affected: R94□s physician orders have been updated to make the pre/post assessment a mandatory task for PRN medication administration. There was no negative outcome for R94. R93□s physician orders have been updated to make pre/post assessment a mandatory task for PRN medication assessment administration. There was no negative outcome to R93. R83□s physician orders have been updated to make the pre/post assessment a mandatory task for PRN medication administration. There was no negative outcome to R83. Identification of others with the potential to be affected: Facility residents with a PRN medication order have the potential to be affected. Facility Nurse Managers completed an audit of facility residents to identify residents that receive a PRN medication order to ensure pre/post monitoring is a mandatory task for medication administration. (Exhibit 17) Measures to Prevent Recurrence: Licensed nurses received education on the need to ensure that when completing a physician□s order for a PRN medication that the pre/post assessment monitoring is triggered as a mandatory task.	

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F 329	Continued From page 29 b. Anxiety: 12 out of 29 administrations of PRN medication for anxiety lacked assessment of resident behaviors: - missing after medication: June 9, July 8, 12 and 13; August 5, 6, 7, 12 and 20; September 3. - missing before medication: June 11, September 11. c. Cough: 7 out of 8 PRN doses without assessment of resident symptoms: - missing before and after medication: June 2, July 21, August 17 and 17. - missing after medication: June 4 - missing before medication: August 19 and 20. During an interview with E5 (UM) on 9/28/17 around 9:45 AM E5 reviewed the several random administrations for R94 in the EMR with the surveyor and confirmed the findings. 2. Review of R93's clinical record revealed: 5/9/17 - Physicians' orders included a PRN medication to be given for anxiety once daily PRN. 5/19/17 - Care plan problem for Behavior Symptoms documented R94 has the following behaviors: delusions; verbal behavioral symptoms directed towards others (yelling and cursing); physical behaviors towards others (hitting, kicking); wandering (pacing). June - September 2017 - Review of eMARs, nursing notes and behavior monitoring sheets completed by nursing included the behaviors of delusions, aggression and yelling/cursing. Many doses of PRN medications lacked resident	F 329	Licensed nurses completed a competency demonstrating the ability to transcribe the order correctly with the mandatory tasks. (Exhibit 4, Exhibit 12) During the 24 hour chart check process, the licensed nurse will review all PRN physician orders to ensure the mandatory task of pre/post assessment was accurately transcribed with the order and reflecting in the electronic medical record. The licensed nurse will print out the medications reviewed in the 24 hour chart check and provide this information to the unit manager as completed and reviewed. Monitoring of Corrective Measures: DON or designee will review PRN medications that have been administered to ensure that the Pre/Post assessment was completed. . The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee.(Exhibit 18)	

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F 329	Continued From page 30 behavior assessment before and/or after their administration: Anxiety: 24 out of 36 administrations of PRN medication for anxiety lacked assessment of resident behaviors: - missing behaviors after medication: June 16, 20 and 25; July 9, 13, 16, 17, 18, 19, 21, 23, 26, 27, 29 and 30; August 4 and 12; September 5. - missing behaviors before and after medication: June 2 and 3; July 10 and 22; August 2, 7 During an interview with E5 (UM) on 9/28/17 around 9:45 AM E5 reviewed the several random administrations for R93 in the EMR with the surveyor and confirmed. 3. Review of R83's clinical record revealed: 4/30/17 - Care plan problem for Behavior Symptoms documented R83 has the following behaviors: delusions (asking for paycheck from working); verbal behavioral symptoms directed towards others (yelling, cursing); physical behaviors towards others (hitting, kicking, pushing); wandering (self propelling in wheelchair). 7/27/17 - Physicians' orders included a PRN medication for anxiety. June - September 2017 - Review of eMARs, nursing notes and behavior monitoring sheets completed by nursing included the behaviors of delusions and aggression. 3 out of 11 administrations of PRN medication for anxiety lacked assessment of resident behaviors before the medication: August 27 and 28; September	F 329		

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F 329	Continued From page 31 21. During an interview with E6 (UM) on 9/28/17 at 11:25 AM E6 had difficulty locating the August, 2017 behavior monitoring sheet, but eventually found it in a stack of papers to be filed in the chart. Around 11:45 AM when the surveyor informed E6 about the behavior monitoring forms indicating R83 had no behaviors on the shifts when the PRN anxiety medication was administered, E6 offered no explanation. These findings were reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM.	F 329		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441		11/27/17

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F 441	Continued From page 32 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 33 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to maintain an effective infection prevention and control program by failing to ensure tuberculosis (TB) testing was complete prior to hire for one (E14) out of 15 sampled recently-hired employees. Findings include: Review of information that human resources recorded on a personnel audit spreadsheet. revealed that E14 was hired on 6/28/17 with a start date of 7/3/17. Step 1 TB skin test was done 7/19/17, step 2 TB skin test was on 7/27/17. During an interview on 9/29/17 at 12:19 PM with E1 (NHA) it was confirmed that the start date was 7/3/17 and the TB skin test was not completed until after the start date. These findings were reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM.	F 441	F441 Corrective Measures for residents affected: There were no residents affected. The employee received the PPD on 07/19/2017. Identification of others with the potential to be affected: Facility Staff Educator completed an audit of all facility employees to ensure that there is evidence of a completed 2 step PPD. (Exhibit 19) Measures to Prevent Recurrence: Facility DON completed one on one education with Staff Educator to review the mandatory task of PPD administration on or before the date of hire. (Exhibit 20) A facility new hire check sheet has been implemented and must be completed prior to allowing the employee to orient on the floor to ensure that required competencies and vaccinations have been completed. (Exhibit 22) Monitoring of Corrective Measures: Facility DON or designee will audit new	

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F 441	Continued From page 34	F 441	hire employees to ensure that the first step PPD was completed on or before the date of hire. . The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee.(Exhibit 21)	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 514		11/27/17

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F 514	Continued From page 35 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure complete and accurate documentation for 4 (R94, R93, R82 and R83) out of 34 sampled residents. The facility failed to accurately document bowel movements and failed to ensure weekly wound assessments were in the clinical record. Findings include: 10/2/16 - Facility policy entitled Bowel Protocol documented that the CNA will document bowel activity in [name of] computer software. 1. Review of the clinical record for R93 revealed: June - September, 2017 - Review of CNA documentation found many missing entries indicating whether or not the resident had a bowel movement: For R93= 28 shifts incomplete. During an interview with E5 (UM) on 9/28/17 around 10:00 AM E5 confirmed the missing documentation for R93. These findings were reviewed with E1 (NHA) and	F 514	F514 Corrective Measures for Residents Affected: There was no negative outcome to R93. The BM documentation has been made a mandatory task in the electronic medical record. There was no negative outcome to R94. The BM documentation has been made a mandatory function for all shifts in the electronic medical record. There was no negative outcome to R83. The BM documentation has been made a mandatory function in the electronic medical record. There was no negative outcome to R82. R82 is followed weekly for the wound. Identification of Others with the Potential to be Affected:	

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F 514	Continued From page 36 E2 (DON) on 10/3/17 at 11:30 AM. 2. Review of the clinical record for R94 revealed: June - September, 2017 - Review of CNA documentation found many missing entries indicating whether or not the resident had a bowel movement: For R94: 30 shifts incomplete (in addition night shift did not appear in the documentation software for that shift to record the resident's bowel movements). During an interview with E5 (UM) on 9/28/17 around 10:00 AM E5 confirmed the missing documentation for R94. E5 also added night shift under the bowel movement documentation for R94 "so it appears now." These findings were reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM. 3. Review of the clinical record for R83 revealed: June - September, 2017 - Review of CNA documentation found many missing entries indicating whether or not the resident had a bowel movement: For R83: 51 shifts incomplete. These findings were reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM. 4. Cross refer F314	F 514	Facility residents have the potential to be affected. Facility nurse managers completed an audit of facility residents to ensure that the documentation of BM□s is a mandatory task on all shifts. (Exhibit 23) Facility residents with pressure ulcers have the potential to be affected. Facility Nurse Managers completed an audit to identify facility residents with pressure ulcers to ensure that weekly wound evaluations are occurring. (Exhibit 15) Measures to Prevent Recurrence: Facility nursing staff received education on the importance of documenting bowel movements in the medical records. Licensed staff also received education on how to make the documentation of bowel movements on all shifts a mandatory task. (Exhibit 4, Exhibit 12) Unit managers received one on one education on the importance of assessing and measuring pressure ulcers on a weekly basis. This education included the need to ensure the assessment/measurements occur even if the NP is not available for rounds. (Exhibit 16) Facility nurse managers will run a missing entry report daily to capture any missing documentation of BM□s. Facility pressure ulcers will be reviewed weekly in the clinical IDT meeting to ensure the wound assessments have	

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	085041	A. BUILDING _____ B. WING _____	10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 E. DELAWARE AVENUE DELMAR, DE 19940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 37 Review of the clinical record for R82 revealed: Weekly wound measurements were not available on the clinical record. 9/27/17 - Review of the EMR and paper clinical record lacked evidence of weekly wound assessment in August 2017. 9/2817 10:17 AM - Interview with E2 (DON) and E4 (UM) confirmed that there were no weekly wound assessments available in the clinical record for August 2017. E4 stated they would contact the contract the wound nurse to see if s/he could send them over. Later in the day wound measurement sheets were provided for 8/14 and 8/25/17. These were sent from the wound consultant. The 8/7/17 measurements were provided on a spreadsheet. These findings were reviewed with E1 (NHA) and E2 on 10/3/17 at 11:30 AM.	F 514	been completed weekly. Monitoring of Corrective Measures: DON or designee will complete an audit of facility Bowel records to ensure that entries have been completed without omissions. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 24) DON or designee will complete audits to ensure weekly wound evaluations occur on residents with pressure ulcers. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 15)	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED:** October 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from September 25, 2017 through October 3, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was eighty five (85). The stage 2 survey sample was thirty four (34).	Delmar Nursing and Rehabilitation Center's plan of correction for the deficiencies noted during our annual survey ending October 3, 2017 is not an admission to the deficiencies, but our desire to show compliance with all Federal and State regulations.	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on October 3, 2017: F225, F272, F278, F279, F280, F309, F314, F329, F441, and F514		

Provider's Signature _____ Title DON Date 10/24/17

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED:** October 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
5.6 5.6.1	**Dementia Training** **Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** Based on review of facility documentation and interview it was determined that for 2 [E6, E8] out of 7 professional staff reviewed the facility failed to ensure yearly dementia training was provided. Findings include: Review of 7 professional facility staff for current dementia training revealed 2 (E6 and E8) did not have training in the past year. Interview with E2 [DON] on 9/27/17 at 1:10 PM revealed that no training could be found for the above employees.	**5.6** **Corrective Measures for Residents Affected:** There were no residents affected. E6 received dementia training on September 27, 2017 and E8 received dementia education on September 28, 2017. **Identification of others with the potential to be affected:** Facility Staff Educator completed a facility wide audit to ensure that all facility employees have received the mandatory dementia education. (Exhibit 25) **Measures to Prevent Recurrence:** Facility Staff Educator received one on one education from DON on the requirement to complete yearly dementia education with facility staff. (Exhibit 20) Facility Staff Educator will be required to complete one section of the mandatory training requirements a month. The Educator will be completing the education plan for the year and providing it to the DON for approval. Staff Educator will be responsible for turning in completed signature sheets monthly to the facility DON. **Monitoring of Corrective Measures:** DON or designee will complete audits of facility employees to ensure the mandatory dementia education has been completed. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 25)	November 27, 2017
Title 16 Chapter 11	**Health and Safety** **Regulatory Provisions Concerning Public Health** **CHAPTER 11. NURSING FACILITIES AND SIMILAR FACILITIES** **Subchapter IV. Criminal Background Checks; Mandatory Drug Screening; Nursing Home Compliance with Title XIX of the Social Security Act** **§ 1141 Criminal background checks.**	**Title 16** **Corrective Measures for Residents Affected:**	November 27, 2017

Provider's Signature _____ Title DON Date 10/24/17

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED:** October 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(a) Purpose. — The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of nursing facilities and similar facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose. **(b) Definitions. —** **(1) "Applicant" means any of the following:** **a. A person seeking employment in a facility, as defined below;** **b. A current employee of a facility who seeks a promotion in the facility;** **c. A self-employed person or a person employed by an agency for work in a facility;** **d. A current employee of a facility or a person as defined in paragraph (b)(1)c. of this section above who the Department of Health and Social Services has a reasonable basis to suspect has been arrested for a disqualifying crime since becoming employed or commencing work;** **e. A former employee who consents prior to leaving employment to periodic review of his or her criminal background for a fixed time period.** **(2) "Background Check Center (BCC)" means the electronic system which combines the data streams from various sources within and outside the State in order to assist an employer in determining the suitability of a**	E10 no longer works at the facility. E11 had a criminal background completed on October 3, 2017. E12 had a criminal background completed on October 3, 2017. There was no negative outcomes to any resident. **Identification of others with the potential to be affected:** Facility staff members have the potential to be affected. LNHA completed an audit of facility files to ensure each employee had a background check on file. (Exhibit 26) **Measures to Prevent Recurrence:** The facility has implemented a new system for contracted staff that ensures that the application including completed background check are provided to the facility. The facility will now maintain and employee file on the contracted employees to include this information. **Monitoring of Corrective Measures:** LNHA or designee will complete audits of employee files to ensure that there is a criminal background check completed on each employee, both facility and contracted. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 26) LNHA or designee will complete an audit of facility new hires to ensure that there is proof of a completed background check on record prior to the start date. The audits will occur on the following schedule: Daily until 100% compliance is noted for 5 consecutive days, then 3 times a week until 100% compliance is noted for three	

Provider's Signature _____ Title DON Date 10/24/17

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED:** October 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	person for employment in a nursing facility or similar facility. **(3) "Criminal history" means a report from the Department of Health and Social Services regarding its review of the applicant's entire federal criminal history from the Federal Bureau of Investigation, pursuant to Public Law 92-544 as amended (28 U.S.C. § 534) and his or her Delaware record from the State Bureau of Identification.** **(4) "Department" means the Department of Health and Social Services (DHSS).** **(5) "Facility" means any facility licensed pursuant to this chapter, including but not limited to nursing facilities (commonly referred to as nursing homes), assisted living facilities, intermediate care facilities for persons with intellectual disability; neighborhood group homes, family care homes, rest residential homes, intensive behavioral support and educational residences; retirement homes and rehabilitation homes with such terms to have such meaning as set forth in this title or, if not defined therein, as such terms are commonly used.** **(6) "Grandfathered employee" means an employee of a facility who was not fingerprinted pursuant to this statute because the employment commenced before the effective date of the statute (March 31, 1999), and no requirement for fingerprinting has since applied (see paragraph (b)(1) of this section above).** **(7) "SBI" means the State Bureau of Identification.**	Consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliant is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 26)	

Provider's Signature _____ Title DON Date 10/24/17

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED:** October 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on review of personnel records for 15 staff it was revealed that 3 [E10, E11, E12]had no evidence of FBI and SBI criminal back ground checks: E10 hired 6/28/17 E11 hired 6/1/17 E12 hired 7/17/17 10/3/17 9:50 AM - Interview with E13 (HR) about not having fingerprinting done revealed E10 has a criminal check that was not done through the approved State system with fingerprinting. The other two staff (E11 and E12) were contract staff had screening through their employer but not through the approved system with fingerprinting. 10/3/17 - Review of the State database revealed E10, E11 and E12 did not have State and Federal criminal background checks with required fingerprinting completed upon employment. This finding was reviewed with E1 (NHA) and E2 (DON) on 10/3/17 at 11:30 AM.		

Provider's Signature _____ Title DON Date 10/24/17